Statewide Transformation Initiative
Involuntary Treatment Act (ITA) Review
Final Report –
Tribal Concerns, Analysis, and Options for Reform

Submitted to

The State of Washington
Department of Social and Human Services
Health and Recovery Services Administration
Mental Health Division

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Tribal Concerns, Analysis, and Options for Reform

A. Overview of Relationships Between MHD and Sovereign Tribes

The relationship between the government agencies of Washington State and the 29 Federally-recognized Tribes located within the State is governed by the Centennial Accord, which provides a framework for government-to-government relationships between the State and each sovereign Tribe. Although the Accord was initiated by the Governor of Washington State, it also recognizes the authority of the "chief representatives of all elements of state government" to ensure complete and broad implementation of the arrangement. The Mental Health Division (MHD), as part of the Department of Social and Health Services (DSHS), thereby maintains a direct working relationship with each of the 29 Tribes pursuant to the Centennial Accord.

While the primary relationship is between the State and each sovereign Tribe, essential relationships have formed between various agents acting on behalf of the State of Washington – including RSNs, Designated Mental Health Professionals (DMHPs), and State-operated treatment facilities such as the State hospitals and Children's Long-Term Inpatient Program (CLIP) facilities – regarding day-to-day implementation of provisions of the State's involuntary treatment laws.

Tribal members are able to access mental health services through multiple systems, including their own dedicated Indian Health Service (IHS) and Tribally-administered 638 facilities (funded by Title I or III of the Indian Self Determination and Education Assistance Act – Public Law 93-638), the Medicaid Prepaid Inpatient Health Plans (PIHPs) administered by the RSNs, or a combination of these systems. Coordination across these systems is supported by the 7.01 planning and policy development process, through which an Updated Report is renewed every two years to coordinate the efforts of DSHS overall, MHD, and the RSNs. Each of the 13 RSNs contracting with MHD are also required to carry out 7.01 planning processes at a local level with the Tribes located in their geographical boundaries.

B. Methodology and Approach

In developing this chapter, the report authors relied on multiple sources of information. First, input was sought directly from representatives of Tribal Governments, Recognized American Indian Organizations (RAIOs), and DSHS Indian Policy and Support Services (IPSS) managers. Initial input was obtained through a Tribal Forum held in February 2007.

Based on input from that Forum, two focus groups involving a broader representation of Tribal Governments, RAIOs, and IPSS managers were carried out in April 2007. One group was held in eastern Washington at the American Indian Health Center in Spokane. The group involved representatives from Colville Confederated Tribes, Kalispel Tribe, and Confederated Tribes of the Yakama Nation; five representatives from RAIOs; and two IPSS staff. The second group was held in western Washington and involved the

Tribal Chairman of the Stillaguamish Tribe; other representatives of seven western Washington Tribes, including Makah Nation, Puyallup Tribe, Shoalwater Bay Tribe, Skokomish Tribe, Stillaguamish Tribe, Tulalip Tribe, and Upper Skagit Tribe; and two IPSS staff. A complete listing of focus group participants is included in Appendix A of this report.

In addition, the authors conducted interviews with DSHS and MHD Tribal Liaisons and interested focus group participants. The authors also conducted additional targeted research regarding how two other States – Arizona and New Mexico – coordinate involuntary treatment with Tribal governments within their geographic boundaries.

C. Key Issues and Concerns

Consistent with the perspectives of stakeholders interviewed for the broader study, Tribal representatives emphasized that a lack of adequate community-based resources too often leads to involuntary treatment for adults and the need for children to be served in residential settings far from their homes and communities. In particular, Tribal stakeholders suggested that Tribal providers are in the best position to know and meet the specific needs of Tribal members but often lack adequate resources to provide mental health and other essential services directly. Tribal representatives noted that many Tribal programs are effective in preventing people from needing to access RSN services, and they suggested that the State should provide funding directly to Tribes to support these programs.

Tribal representatives also pointed to a general lack of coordination between RSNs and Tribes as a major concern. Although RSNs are required, through the 7.01 planning process, to develop Tribal collaboration plans, many Tribes said that these plans are not effectively implemented or adequately monitored by MHD. These Tribes said that the expertise of Tribal and RAIO mental health and broader human services staff often were not integrated into care decisions, resulting in Tribal members with mental illnesses failing to receive culturally competent services – or any services at all – until they are in crisis.

Tribal stakeholders also expressed specific concerns related to the involuntary treatment process itself, including the following:

(1) Lack of Tribal jurisdiction to detain an individual under the civil commitment laws or authorize inpatient services at State hospitals. In Washington State, if a Tribal court or provider identifies a person whom they believe requires involuntary treatment, the Tribe must contact the RSN in which the Tribe is located to request an assessment by a Designated Mental Health Professional (DMHP) for a determination regarding whether the person can be detained.

Some Tribes reported a smooth working relationship with DMHPs who generally agree to detain when recommended by Tribal providers or courts, but others said that DMHPs are not responsive to their requests and often make detention decisions with little or no

input from Tribal providers or representatives. According to one DSHS Tribal Liaison interviewed, a Tribe that contacts a DMHP to request a 72-hour detention may or may not succeed in having the DMHP even agree to conduct an assessment, depending on the Tribe's relationship with the RSN. The dependence on non-Tribal DMHPs can also result in delays in access due to travel, particularly in eastern Washington, where waits of eight hours or more were noted given the distances involved.

Formal DMHP Protocols provide only general guidance to DMHPs regarding detention of Tribal members. Protocol 135 of the 2005 Protocol Update provides:

> DMHPs should consult with the county prosecuting attorney regarding any interlocal agreements between the RSN and tribal governments. Tribal governments have authority over activities on Federally recognized tribal reservations. Individual RSNs are currently in the process of developing interlocal agreements with tribal governments on the conditions and procedures for conducting ITA investigations and detaining American Indians on tribal reservations.

In focus groups conducted in connection with this report, many Tribal representatives said they were not aware of any formal agreements or protocols between their Tribe and the relevant RSN for contacting and working with DMHPs.

(2) Lack of communication between Tribes and RSNs during involuntary treatment and discharge. Many Tribes noted that, when a Tribal member is detained under the involuntary treatment law, he or she is transported to a community hospital operated by non-Tribal providers for an evaluation. If the hospital petitions for a longer commitment period, the Tribe will not be engaged either in that process or in any subsequent legal processes related to the commitment. More important, according to some Tribal representatives, Tribes generally are not notified when a Tribal member is admitted to a State hospital, nor are they given an opportunity to be engaged – in contrast to RSNs – in planning for discharge. This lack of communication distances the individual from the natural and community supports that the Tribe provides and results in fragmented, uncoordinated services when the person is discharged.

(3) Need for direct negotiations between Tribes and the State. Although some Tribes reported having a functional, effective working relationship with their RSNs, all Tribes participating in focus groups agreed that they should have direct access to negotiations with the State regarding involuntary treatment. This is especially important because, while some Tribes may want to order detentions or civil commitment independent of RSNs and non-Tribal courts, others may lack the resources or clinical and legal capacity to do so. Tribal representatives emphasized that the Centennial Accord defines the relationship of Tribes to the State as a government-to-government relationship, and agreed that it was inconsistent with that agreement to require Tribes to negotiate with RSNs instead of the State.

D. Other State Approaches

The authors reviewed the approaches used in two other States – Arizona and New Mexico – regarding Tribal roles and responsibilities related to involuntary treatment. In Arizona, State mental health services are provided through Regional Behavioral Health Authorities (RBHAs), which operate much like Washington State's RSNs. Tribes in Arizona may elect to operate their own RBHAs (referred to as Tribal-RBHAs or T-RBHAs). Some Tribes operate T-RBHAs fully independent of the non-Tribal RBHA in their geographic service area, some operate partial T-RBHAs that directly oversee some services and coordinate others through the non-Tribal RBHA, and others rely fully on their non-Tribal RBHA.

Regardless of whether a Tribe has established a full or partial T-RBHA, Tribal courts and their representatives may elect to order detention and civil commitment directly or to rely instead on their RBHAs and the non-Tribal court system. Tribes in Arizona therefore have a choice about whether they want to collaborate with their regional State-designated mental health contractor and the scope of any collaboration undertaken, both for the initiation and provision of involuntary treatment, as well as for broader care provision.

Arizona statute defines the roles and responsibilities of both the State and the Tribe, ensuring that Tribal court orders are enforceable but allowing the attorney general five days to object to a civil commitment order:

> A. Notwithstanding any law to the contrary, an involuntary commitment order of an Arizona tribal court filed with the clerk of the superior court shall be recognized and is enforceable by any court of record in this state, subject to the same procedures, defenses and proceedings for reopening, vacating or staying as a judgment of the court. The Arizona supreme court may adopt rules regarding recognition of tribal court involuntary commitment orders. The state, through the attorney general, shall be given notice of the filing at the time the commitment order is filed and shall have five days from receipt of the written notice of the filing of the order to appear as a party and respond. A patient committed to a state mental health treatment facility under this section shall be subject to the jurisdiction of the state.[1]

Subsection B of the statute requires formal notification of the Tribal court before an individual committed by that court is discharged:

> B. Decisions regarding discharge or release of a patient committed pursuant to subsection A shall be made by the facility providing involuntary treatment. Ten days prior to discharge or release, the state mental health treatment facility shall notify the tribal court which issued the involuntary commitment order of the facility's intention to discharge or release a patient. Any necessary outpatient follow-up and transportation of the patient to the jurisdiction of the tribal court, within the time set forth in the notice, shall be provided for in an

[1] Ariz. Rev. Stat. 12-136-A.

> intergovernmental agreement between the tribe and the department of health services.[2]

In New Mexico, a single Statewide Entity (SE) is responsible for managing Medicaid and other publicly funded mental health services. In that role, the SE is required to establish direct linkages with Tribal courts, although the nature of those linkages is not prescribed by statute. The 2007 Statewide Behavioral Health Services Contract provides:

> The SE shall ensure that linkages with Tribal, Nation, and Pueblo Courts; IHS; Bureau of Indian Affairs (BIA); and Tribal, Nation, or Pueblo 638 programs are developed at the SE level and shall ensure that its subcontracted providers have established linkages with the preceding agencies in order to ensure appropriate coordination of care for Native American consumers utilizing those programs.[3]

In Washington State, RSNs are required to develop 7.01 collaboration plans with Tribes, but there is no requirement that these plans include linkages with courts or recognition of Tribal court orders.

E. Options for Reform

One option to address a common Tribal concern would be to allow Tribes to detain individuals independent of RSN approval. This could be accomplished by giving Tribes and Tribal Courts the ability to appoint Tribal DMHPs with authority to order involuntary treatment independently. RCW 71.05.020(10) defines a DMHP as "a mental health professional designated by the county *or other authority authorized in rule* to perform the duties specified in this chapter." This language suggests that DSHS could authorize Tribes to designate DMHPs without requiring a statutory change, so long as Tribal DMHPs meet all other statutory and administrative requirements.

Because Tribes vary significantly in their capacities to provide the needed clinical assessment and ensure due process protections for individuals who are detained, some Tribes may opt to designate a Tribal DMHP while others may choose to continue to coordinate with RSNs regarding detention. Allowing each Tribe to decide its own approach would be consistent with Tribal sovereignty as reaffirmed through the Centennial Accord and as reflected in other areas of mental health service delivery. For example, Tribes currently are able to access services through Indian Health Services, operate their own 638 facilities, or access services through RSN provider networks.

A second option would be to require RSNs to accept referrals for 72-hour detentions from Tribes, rather than, in the words of one focus group participant, "wasting resources" by engaging a DMHP to conduct an additional assessment. This could be negotiated directly by Tribes with RSNs or, consistent with the government-to-government relationship that Tribes have with the State, the State could impose specific requirements on RSNs with respect to Tribal referrals.

[2] Ariz. Rev. Stat. 12-136-B.
[3] 2007 Statewide Behavioral Health Services Contract, Section 3.16.M.

It is important to note that Washington State only recently consolidated decision-making authority and financial responsibility for involuntary inpatient services with RSNs. This structure ensures that involuntary treatment is used only as a last resort and serves as a check on unnecessary inpatient utilization. Therefore, a significant concern regarding the two options provided here is that the nexus between decision-making and financial responsibility for involuntary treatment would be broken, giving Tribes the ability to detain Tribal members while RSNs remain in the role of payer. Should Tribes be given the option of designating DMHPs or if RSNs are required to accept Tribal referrals, some mechanism must be established to ensure uniform accountability for the use of involuntary treatment and inpatient utilization. Consideration of these issues should occur in the context of other recommendations regarding the authority of Tribes to deliver mental health services, including recommendations in the Benefit Design report to explore options for allowing Tribes to directly operate RSN functions. Establishment of Tribal DMHPs could also raise new issues about whether detention criteria are applied uniformly and where evaluations during the 72-hour detention period would be conducted.

Appendix A

2/5/07 Focus Group re: Tribal Issues -- Tacoma
Helen Frenrich, Tulalip Tribe
Ric Armstrong, Quinault Tribe
Deb Sosa, American Indian Health Center
Jennifer LaPointe, Puyallup Tribe
Doug North, DSHS Indian Policy and Support Services
Sharri Dempsey, DSHS Indian Policy and Support Services
Carmelita Adkins, DSHS Indian Policy and Support Services
Avreayl Jacobson, DSHS MHD

4/17/07 Focus Group re: Tribal Issues -- Spokane
Joseph Waner, Kalispel Tribe
Gladys Yallop, Yakama Tribe
Linda Lauch, American Indian Community Center
Judy Johnson, American Indian Community Center
Sophie Tonasket; American Indian Community Center
Cindy Robinson, N.A.T.I.V.E. Project
Sarah Jamison-Jeter, N.A.T.I.V.E. Project
Phil Ambrose, DSHS Indian Policy and Support Services
Bob Brisbois, DSHS Indian Policy and Support Services

4/18/07 Focus Group re: Tribal Issues – Seattle
Doug Mayer, Makah Nation
Linda Thomas, Skokomish Tribe
Jeanne Paul, Shoalwater Bay Tribe
Adrianne Hunter, Upper Skagit Tribe
Shawn Yawity, Stillaguamish Tribe
Edward Reser, Stillaguamish Tribe
Jennifer LaPointe, Puyallup Tribe
Sheryl Fryberg, Tulalip Tribe;
Sharri Dempsey, DSHS Indian Policy and Support Services
Doug North, DSHS Indian Policy and Support Services